Form 206 11/2004

STATE OF UTAH – LABOR COMMISSION

Division of Industrial Accidents
P. O. Box 146610, Salt Lake City, UT 84114-6610

INJURED WORKER STATUS REPORT

Directions: This report must be submitted when an injured workers' temporary total disability compensation period exceeds 90 days or when it appears that an injured worker is or will be a disabled injured worker, whichever occurs first. (Section 34A-8-106)

GENERAL INFORMATION

Name		Claim Number
Address		Date of Injury
Phone Number	Social Security Number	Occupation of Injured Worker
Employer (Name, Address, Phone Number)		Pre-injury Weekly Wage $ _____
Insurance Carrier – Adjustor's Name & Phone Number		
Private Rehabilitation Provider (Name, Phone Number)		

STATUS – EXPECTATIONS OF RTW: Employer: _____ Employee: _____

_____ _____

☐ **A. Reemployment Assistance IS Necessary**

Check "A" if reemployment assistance is needed; also, circle recommended services.

* Counseling
* Vocational Evaluation
* Job Placement
* Job Seeking Skills
* Reemployment Plan
* On the Job Training
* Transferable Skills Analysis
* Jobsite Modification
* Coordinate Reemployment
* Retraining

Referral for vocational rehabilitation services are made to a qualified rehabilitation provider:

Agency _____

Counselor _____

Referral Date _____

☐ **B. Unable to Determine Need or Proceed with Assistance**

Check "B" if any of the following are true; also, circle appropriate response below.

* Not yet medically stable (no MMI date) and physically capacity yet to be determined.
* Worker is currently involved in light duty "trial work activities.
* Claim liability is under review.
* Worker has marketable skills, 60 day monitoring begins:
  DATE ____/_____/____
* Worker has returned to work, 60 day monitoring begins:
  DATE ____/____/____
* Briefly describe the Postponement:

Estimated Date of Resubmission:
_____

☐ **C. Employment Assistance is NOT Necessary**

Check "C" if reemployment assistance is not necessary.
(Specify reasons below.)

* Worker returned to work (RTW) and 60 days monitoring complete:

  Date RTW ____/____/____
  Same Employer _____
  New Employer _____
  Self Employed _____
  Same Job _____
  New Job _____
  Modified Job _____
  RTW wage $_____ Wkly. wage

* Worker RTW as a result of vocational rehabilitation support services.

  Type of service(s) _____
  _____
  Cost of Service(s) _____
  _____

* Disability too severe to return to work.
* Other (specify) _____
  _____

cc: Injured Worker